Missing Bodies:

Experiences of Pregnancy Loss in a Public Hospital in Mexico City

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Summary

Rationale and aim

Pregnancy loss is a common phenomenon that raises questions of anthropological interest (body, personhood, life, death). However, this topic has received little attention from anthropologists or other social scientists. This thesis explores the ways in which the experience of pregnancy loss is shaped by the organization and culture of biomedical practice in Mexico and by the use of technologies. It also analyzes the ways in which Mexican women cope and try to make sense of their loss.

Methodology

The thesis is the result of a qualitative study with an ethnographic approach that draws upon three main theoretical perspectives (biomedicine as a cultural construction; biopower and authoritative knowledge; notions of body, self and personhood). It was carried out at the Woman’s Hospital, a public federal institution in Mexico City during May and June 2009. The main data collection techniques were participant observation and in depth-interviews with women and hospital staff.

Findings

In this hospital, the biomedical knowledge and practices regarding pregnancy loss are shaped by resident’s work overload and particular notions of women’s inability to take care of themselves or being ignorant, features that implied a risk for both women and physicians. These practices contradict international pregnancy loss management guidelines. Women’s experiences were shaped by the lack of access to health care, the anguish and uncertainty of being in an unknown environment without proper information about their condition and the medical procedures they would undergo. In some cases, they were undeniably mistreated.

The sociocultural construction of the pregnant self and the baby inside women’s social networks had begun in the moment they found out they were pregnant. Loosing that pregnancy implied the sudden destruction of these two entities and was experienced in terms of both physical and emotional suffering. Women felt guilt, shame, and regret and regarded their bodies as useless.

Conclusions

The factors influencing women’s experience of pregnancy loss were related to the structural deficiencies of the Mexican Health Care system and the local biomedical practices and attitudes in Woman’s Hospital that entail lack of information, paternalistic attitudes and the need to discipline women’s bodies. Another important factor was the previous construction of the mothers-to-be and the babies inside women’s social networks making of pregnancy losses a devastating “assault on the sense of self”
Abbreviations

ER: Emergency Room

IMSS: Mexican Social Security Institute (Instituto Mexicano del Seguro Social)

IUD: Intrauterine (contraceptive) Device: instrument inserted into the uterus to prevent pregnancy.

MOH: Ministry of Health

NICU: Neonatal Intensive Care Unit

OR: Operating Room

OSU: Obstetrical Surgical Unit

PHI: Popular Health Insurance

SHS: State’s Health Services

US: Ultrasound; ultrasound scanning
1. Introduction

Pregnancy loss is a common phenomenon. Despite the technical and methodological problems to measure it and the variations between countries, it is thought that around 10-20% of all recognized pregnancies end in pregnancy loss. Numbers may rise to 30-40% if the cases of non-recognized early conceptions are taken into account (Petitti, 1987, Wilcox et al, 1988).

As Cecil (1996) argues, pregnancy loss raises a number of questions of anthropological interest. It deals with ideas about the body, life, death and rituals, questions of humanness, personhood and the beginning of life, that have been the focus of much anthropological investigation; however, the loss of a pregnancy in its different presentations (miscarriage, stillbirth, etc) has received little attention from anthropologists. Cecil argues that this may be related to the apparent low social impact of this event since it “does not result in the creation of a new person who is to be incorporated into society, neither is the loss of one who has been recognized as part of the existing social order” (1996:1).

As we can see in Cecil’s compilation of papers on the subject, most anthropological research on pregnancy loss has been carried out in Non-Western settings such as India, Jamaica, Papua New Guinea, Tanzania and Cameroon, focusing in what is called ethnoembriology: the explanatory models and experiences in these settings. One remarkable exception is Layne’s (2003) work on this topic in the context of pregnancy loss support groups in the USA.

Several works in anthropology and in science and technology studies have explored the ways in which technologies affect the experience of pregnancy; particularly, visualization technologies such as ultrasound have been widely studied. These works have shown the power of the visual information derived from ultrasound in making women to reflect on and rework their experiences of pregnancy and they have argued that ideas about the foetus attached to images are not based in supposedly value-free scientific facts but are created through discourse and practice in specific historical and cultural settings. Special attention has been paid to the creation and use of the foetal subjects in the context of anti-abortion vs. pro-choice struggles in which the first group has made use of the foetal images to attach
notions of personhood to the embryo/foetus and used this to discourage women from having an abortion: fighting for the rights of that “little person” who is presented as a separate individual, pictured as free-floating and detached from the woman’s body (cf. Petchesky in Stanworth, 1987, Duden in Morgan & Michaels, 1999).

Closely related to this sphere is the concept of bonding, used not only by anti-abortionists but also in medical realms. This theory associates the pleasure that women take in the sight of ultrasound imagery (as found, for example by Mitchell & Georges (1997)) with the social and emotional transformations that occur in pregnancy, accelerating the “natural process” by which pregnant women enter specifically in a relationship with the foetus (Taylor, 2008).

These notions of “bonding” and the familiarity with the “foetal presence” have been incorporated into the regulation of abortion in the USA. Not only, as said before, foetal images are used in anti-abortion campaigns. In several states of the USA, legislation requires that the woman gets an ultrasound before consenting to an abortion. Supposedly, this is because only by seeing the embryo she will be able to make a fully “informed” consent. This morally (not medically) informed consent has the underlying assumption that women will be less likely to choose an abortion after seeing the image of what it is already characterized in public culture as a baby (Sanger, 2008).

However, the effect of technologies on reproducing and reconfiguring understandings of and relationships with the foetus has not been well explored in the cases of pregnancy loss. Finally, while there is a considerable legacy of anthropological studies exploring the processes and interactions between biomedical knowledge and practices and women’s issues such as menstruation, birth and menopause, biomedicine has not been re-examined in the context of pregnancy losses.

This research attempts to fill the aforementioned gaps by exploring the ways in which the experience of pregnancy loss is shaped by the organization and culture of biomedical practice in Mexico and by the use of technologies. It also begins to explore the ways in which Mexican women make sense of it.
This thesis is divided in three main sections: In *The Context*, I present some particularities of the Mexican Health System and the changes it has experienced in recent years, and I introduce the hospital in which I did my research and its history. Next, I focus on one specific part of the hospital: the imaging ward, and show how the technology of ultrasound is used in this specific context; finally I explain the Mexican medical education system with a special emphasis in gynaecology and obstetrics training.

All of these things – the organization of health care, the place of the hospital within the health system, the use of technology, the values and constraints with which professionals operate - influence women’s experiences of pregnancy loss. In the next section: *Biomedicine, Biopower and Authoritative Knowledge* I explore the hospital daily practices in cases of pregnancy loss as part of the learning process of residents, and the notions and values that come into play. The *Women’s Experience* section starts with an analysis of the cultural construction of the *mother-to-be* and the *baby* as well as the embodiment of the *pregnant-self*. I go on to discuss the way in which women move within the health care system when unexpected things happened and women’s narratives on their experience of pregnancy loss and the ideas and meanings attached to it.
2. Methodology

When I arrived in Mexico City at the beginning of May, I was feeling a little bit anxious about the AH1N1 influenza epidemic that was in the spotlight and its possible impact on my fieldwork, but I also felt confident about my well-structured proposal and clear plan. By spending some time inside the hospital, making observations and interviewing women and doctors, I was going to be able to explore how visualization—“seeing” the foetus on the US monitor—affected the experience of pregnancy loss. I was going to focus in particular on women whose pregnancy loss was of the kind known as blighted ovum.

However, the methodological challenges and ethical dilemmas I found during fieldwork had nothing to do with the epidemic that seemed to have vanished.

I had to wait two weeks before being able to meet the hospital director. I used that time to make some contacts and conduct other interviews. My first appointment with him went well: I was astonished to find out he was not only enthusiastic about having a medical anthropologist in the hospital but familiar with social sciences and willing to introduce them to inform hospital policies. He suggested that I include all kinds of pregnancy loss in my study since he doubted that in such a short period of time I would be able to find enough cases of anembryonic pregnancies and follow them through the diagnosis process, not only for its frequency but because women, instead of getting the proper antenatal care in that unit, usually arrive when already diagnosed or miscarrying. I will explain later the more important reasons I found that would have made it impossible to focus in this particular type of pregnancy loss.

The hospital director also said that knowing the staff, I wouldn’t have enough time to build rapport as “a medical anthropologist doing research for a foreign university” and it would not only create troubles for my research but complaints among the nurses and residents who are not familiar with this practices and would feel scrutinized and threatened. He decided to introduce me as a psychologist grad student doing some academic practices. The only ones who would know about my real status would be the people in the Psychology Department, two great women who helped me throughout the way and opened many doors for me.
Still thinking about what to do with these two unexpected issues, I visited the Imaging Department, in which ultrasounds are performed. I was shocked when I found out that women were not allowed to see the screen. How could I explore the ways visualization affects the experience of pregnancy loss when women cannot see anything?

My whole research plans and questions seemed useless at that point. I decided to cling to my interest on exploring the experience of Mexican women going trough pregnancy losses, their ideas, notions and feelings as well as the role of technology in this phenomenon, but I needed a broader approach. Facing such confusion, I decided to simply sit down with a couple of women and speak about their experiences in order to get inspiration to reformulate new theoretical and methodological approaches.

This need of reformulating my research project -that in that moment I regarded as a dreadful inconvenience- turned out to be quite positive; it allowed me to be flexible and follow the flow of information and leads as they were coming out within women’s narratives, letting them be the ones who determined what was important in their complex realities, instead of trying to make data fit into my structures.

This could not be a reflexive and honest account if I didn’t say that the unexpected decision of introducing me as a psychology student meant letting go of my ego. I had been enthusiastic at returning to a hospital but this time as a medical anthropologist instead of a medical student. But most importantly, it put me in the middle of very strong ethical dilemmas and was a big source of stress during all fieldwork.

I was very uncomfortable with the idea presenting myself as someone I was not, but I did not feel in the position of contradicting the person who was opening the doors of the hospital to me. I knew that it would take a lot of creativity from me to deal with people’s questions without blatantly lying, but, furthermore: How could I stick to my ethics and get a fully informed consent from informants if I was not able to explain the real purpose of my presence there?

Looking back, it was not the very big issue I thought it would be. It did help me to move within the hospital and be regarded as inoffensive, though at the end some people knew,
or at least suspected, the truth and at the very last days of my stay I went through a difficult mishap when the nurses stole my fieldwork notebook.¹

My major concern, being honest with my informants, turned out to be easier than I thought. I introduced myself to patients as someone who was spending some time assigned to the psychology department to learn more about the experience of pregnancy loss as part of my studies. They never seemed to be interested in my professional background but were glad that someone wanted to listen to them; most of them thanked me for the interview since it was their first chance to speak about their feelings and experiences. Moreover, they not only didn’t have a problem with me using their stories for academic purposes but also were enthusiastic about the idea of contributing to broaden the knowledge on this topic.

It wasn’t that easy with the doctors, but after my initial rambling (trying to avoid lies without being explicit about my status) and once they realized the kind of information I was looking for, they relaxed and were open and kind most of the times.

The biggest source of internal conflicts resulted from me being a medical doctor. My previous knowledge constantly challenged my pursuit of the “outsider’s perspective” since I was able to understand doctor’s words, translate US images and got information patients did not. It also meant an effort to change my way of communicating with people. Physicians are used to asking precise questions and expect concise answers that allow them to translate that “data” into diagnosis and treatment flowcharts, overcoming this used style of yes/no, what and how much questioning was an initial challenge. I also found it difficult to de-construct the complex system of hierarchies and prejudices I had internalized and “normalized” as a medical student.

Also due to my medical background, I faced a few strong ethical dilemmas, for instance, one of the informants provided me enough information to know that her loss had been probably caused by medical malpractice outside the hospital. In other occasions I didn’t know what to do when women expressed their complete lack of information and medical explanations and I knew I could explain them their situation and by doing so, help ameliorate

¹ I left it in the nurse’s cabinet that they had kindly offered me to keep my personal belongings. When I got it back it was missing some pages and someone had left a note saying that I should be more careful if I didn’t want others to read my ideas. I hadn’t written anything about them. I guess they needed to state their power and “defend their territory”.
their guilt and confusion. A couple of times I knew, thanks to the interviews, some medical information that women hadn’t told to the doctors and that I considered important. All I can say is that I acted strictly in accordance to my own ethical codes and personal beliefs and did the best I could to manage each situation.

In relation with the influence of my own pregnancy loss on the research process, and even though I needed high levels of self-awareness and reflexivity, I regard my experience as quite positive; it allowed me to ask questions and explore pathways that other researchers wouldn’t think about, doing it in a sensitive way, but also with a convenient distance that the fact of having a very different engagement with biomedicine created between participants and me.

Data collection was made through ethnographic observations in the hospital and in-depth interviews:

*Observations in the Imaging Ward*

I spent several mornings observing the dynamics in the ultrasound-imaging ward. Since the number and kind of patients varied every day, I was there not only in cases of pregnancy loss but also in “normal pregnancies” check-ups and other tests. At the beginning I was allocated to one of the rooms with the same gynaecology resident, but later gained access to the other rooms and was able to pick the cases of suspected pregnancy losses.

*Observations in the Complicated Puerperium Ward*

I spent most of the time in this part of the hospital conducting interviews. However, time spent waiting for patients to be ready for the interviews, breaks and casual visits allowed me to observe the way things work in this area as well as the dynamics between and among patients and hospital staff.

*In-depth interviews with women*

I did 15 in-depth interviews with women in the Complicated Puerperium Ward. Two of them where exploratory, therefore I used 13 as part as the data analysis process. After inviting women to participate I asked them whether they wanted to move to a private space next to the ward, but they usually preferred to stay in their bed. I later understood that the other women in the ward had already shared part of their stories and that privacy of thoughts
was not an issue in a place without privacy of the body. None of them refused to participate, only one refused the used of recorder and I got their permission to fully use their stories for any purposes.

*In-depth interviews with hospital staff*

I interviewed two radiologists, one 4th year resident, one 2nd year resident, one gynaecologist, the chief of the pathology department, the hospital epidemiologist and a group of nursery students.

*Focus Group Discussion*

I was asked to organize a FGD with first year medical residents to explore the topic of mistreatment. At first I thought it would compromise my supposedly passive and observant position but it gave me an insight on residents points of view and was a source of contacts for further interviews and informal conversations.

*Other data collection techniques*

I went through medical books, brochures for patients, wall posters, newspapers and web pages that could enrich my research and interviewed a specialist in counselling for bereaved parents.

All recorded interviews were fully transcribed. Field notes and relevant data collected from the medical records were included in the transcriptions. Data was coded and analyzed to extract the principal patterns and concepts as well as the underlying assumptions and ideas encompassing them. I used pseudonyms to protect my informants’ privacy. The hospital name is the actual one: Woman’s Hospital (*Hospital de la Mujer*) as agreed with the hospital director, who regards this decision as a sign of the openness of the institution to medical anthropological scrutiny and of its interest in incorporating knowledge derived from social sciences into hospital practices.
3. The Context

In this chapter, I present different elements that influence women’s experiences of pregnancy loss. I first explain in broad terms the ways in which the Mexican Health System works and the structural changes it has gone through during the past decades. This helps us understand the women’s lack of access to health care that will be discussed later. I go on to describe the hospital in which I did my research and then focus in a particular area, the imaging department. Finally, I elaborate on the process that Mexican medical students must go through in order to become gynaecology and obstetrics specialists. Gaining an insight into these processes is needed to understand the daily dynamics in the hospital and the biomedical knowledge and practices constructed in this particular context that will be presented in the following chapter.

3.1 Mexican Health Care System

Mexico and its 107.8 million inhabitants create a complex scenario made up by contrasts between and within rural and urban areas, wealth, poverty and ethnic groups. Disparities are also present in the Mexican Health System and around 60% of the population lack social security health insurance.

The system has been severely affected by budget restrictions caused by financial crises such as the early 80’s external debt crisis that affected several countries in Latin America and, in the case of Mexico, led to a dramatic decrease in public health expenditure. Since then, the system has undergone several reform processes and nowadays is still a highly fragmented inefficient structure.

The system is divided into two main branches, private and public health care:

Private Health Care is very heterogeneous, ranging from low-cost physicians’ offices and small hospitals (85% of them with 15 beds or less) to high-quality, state of the art medical services affordable for only a privileged part of Mexican society. Private health care is paid out-of-pocket or through private insurance.

2 The 2005 total health expenditure was 6.4% of the Gross Domestic Product with a Health Expenditure per capita of USD464. Source: Secretaría de Hacienda y Crédito Público, Mexico; OECD Health Data, 2007
Public Health Care is divided into two main sectors:

- Social security health services for insured workers. This category is subdivided into diverse institutions, such as the Mexican Social Security Institute (IMSS), the Institute of Social Security and Services for Civil Servants (ISSSTE), Services for state-owned oil company, etc. These institutions are federal or state based.

- Public Health Services for “open population” -without the abovementioned employment-related social security insurance-. These public services are provided in a decentralized organization, by the 32 the States' Health Services (SHS) belonging to the Ministry of Health (MOH). There are few hospitals and institutes that didn’t undergo the decentralization process (see below) and remain as federal entities. A program called Seguro Popular (Popular Health Insurance, PHI) has been slowly introduced since 2004, providing for the uninsured population.

But in practice, patients cross the lines of these separate components. For example, people insured by the social security institutions can seek care at the SHS if services are closer or better for them. It is well known that at all economic levels and despite having public insurance, people seek care among the multiple private services that are offered, making out of pocket health expenditures nearly half of the total health expenditure in the country. These choices are shaped by the significant differences in quality of care across clinical settings and users accessibility to the different components of the system (c.f. Barber, 2006; Puentes et al. 2006)

Among the private practices, one that turned out to appear constantly in women’s narratives is what they called Similares. In 1997, a Mexican businessman and politician (candidate in the 2006 presidential election) created “Grupo Por un País Mejor”, a group of enterprises that produce, distribute and sell drugs. They established several drugstore franchises within the country and next to each, a little private practice offering very cheap consultations (1-1.5Euros) provided by general practitioners who prescribe the drugs the same company sells next door.
3.1.2 Health System Reform

Since 1995, the system has undergone a substantial reform. From 1995 to 1997 two main changes were implemented: one at the Mexican Social Security Institute (IMSS) and the other one at the Ministry of Health (MOH). At IMSS, there was a shift in the funding scheme from contributions proportional to income to a uniform premium for employers, a small premium proportional to income for workers and a uniform government contribution. Some detractors as Laurell (2007) argue that these changes in the scheme of contributions for IMSS were influenced by the World Bank “conditionalities” and neoliberal agendas that introduced a damaging market logic into the assignment of health resources through its “equal pay for equal services” and “fee for service” policies, abandoning the solidarity principle of “services according to the need”.

The changes at the MOH level consisted in the World Bank-inspired decentralization of care provision to the state level, a definition of a “free essential health package” for all population and, at specialty hospitals, the elimination of fee exemptions. (2007:516-517). The decentralization process had had poor results due to a lack of consensus among the social actors involved. In many cases, householders and state and municipal governments disagreed on the increase of local financing support for health care (Arredondo et al., 2004) health workers were (and are) reluctant to accept rural postings because they do not entail any benefit but a detriment in living and working conditions compared with urban areas. The decentralization process became frequently a re-centralization process at the state-capital levels. (Kolehmainen-Aitken, 2004). Decentralization has played an ambiguous role in solving the health care crisis in México, what have been benefits for some, represent liabilities for others (cf. González-Block, 1989)

The next milestone in the Mexican health system reform was the creation, in 2004, of the Popular Health Insurance (PHI). Its objective is to bring health care to the uninsured population. Its funding comes from federal tax money, states tax money and money from the users who pay an annual premium with the exemption of families in the poorest 20 percent of the population. This voluntary affiliation was aimed to expand by 14.3% per year, meaning universal coverage by 2010. This program comprises an explicit benefits package, including

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3 To meet the needs of the population, the MOH has agreements with universities and schools of medicine that send undergraduate students to carry out the mandatory year of social service in those areas making of young inexperienced practitioners the only source of medical care for the entire community.
prescribed authorized drugs and some high-cost interventions. The rest of the services are paid by the user. Care is provided by the state ministry of health of the user’s place of residence or, alternatively, by other health institutions (either public or private) certified by the MOH to guarantee quality of care standards. PHI subsidies are authorized annually according to the number of enrolled families.

According to its creators, PHI was designed after “deliberations on the moral implications of the existing institutional arrangements” (Frenk & Gómez-Dantés, 2009:1406). The discourse surrounding the implementation of this program makes constant allusions to ethics, equity and “justice in financing” by offering full coverage for specific diagnosis called "catastrophic diseases" (those that could compromise a family's patrimony if they had to pay for the medical care of a relative) and covering about 95% of all causes of hospital admissions.

Once again, one of the voices presenting an alternative view on this program is Laurell (2007) who vehemently criticizes PHI as a violation of the Mexican constitutional right to Health Protection by conditioning the service to purchasing insurance. She also questions the validity of the evidence-based research that informed the policy design since the majority of references presented come from researches conducted by the same team that created the policy, and “the global knowledge” on which this program is allegedly based came from the World Health Report 2002, created by the same author of the PHI. Moreover, she explores the imprecision and vagueness when defining the covered interventions and the inequity in the fixed state premium that doesn’t consider the economical variations between states.

It is not the purpose of this paper to provide a full analysis of the different perspectives on the Health System Reform. Suffice it to say that beyond “politics in policies” the Mexican Health System is highly fragmented, chronically underfunded and politically contested and that the human right to health and medical care is still a long way off for many Mexicans.
3.2 The Woman’s Hospital

The hospital dates from the 16th century when it was created by a medical doctor and later managed by different religious orders, sustained through charity. It was dedicated to provide care for the most vulnerable groups such as indios, negros, mestizos and mulatos (who were indigenous, “black and mixed race” people) and later for prostitutes.

After several names, managers and different purposes, it gradually started its consolidation from the end of the 19th century to become what it is today: a public federal hospital under the supervision of the Ministry of Health, (meaning that it didn’t take part in the abovementioned decentralization process). It is located in Mexico City and is considered a 3rd level hospital\(^4\) that provides care to patients in the areas of gynaecology, obstetrics, oncology as well as neonatal care for people from all over the country lacking public social security insurance. They charge relatively small fees, based on the socioeconomic status of the patient. It has 285 beds and it’s an institution in great demand; for instance in 2007 12,482 women were hospitalized; in 2008 26,959 consultations were provided at the Emergency Room.\(^5\)

The hospital has been recently redesigned and is now a medium size modern neat building, with several human and material resources, absolutely non representative of the reality of many other Mexican public hospitals I came to know as a medical student. This is a teaching hospital, with residents doing a specialization in gynaecology/obstetrics and neonatology, undergrad interns (students on the 5th year of medical school) and undergrad medical and nursery students. It is divided in two main areas:

- **The Outpatient Clinic**, which comprises the following services: gynaecology, obstetrics, oncology, high-risk pregnancy, endocrinology clinic, dysplasia clinic, infertility clinic,

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\(^4\) First level institutions are Health Centres of Family Medicine Units, attended by general practitioners, Second level comprises General Hospitals with the basic specialties services (gynaecology and obstetrics, surgery, internal medicine and emergency medicine) and Third level institutions are focussed in one specialty.

\(^5\) Data obtained at the Department of Epidemiology and Statistics of the hospital
dentistry, care for women in violence situation, and children motor skills development (early stimulation).

- **The Hospitalization Area**, that includes: neonatology, complicated puerperium, perinatal medicine and high-risk pregnancy, shared accommodation, surgery, obstetrical surgical unit, adult and neonatal intensive care units and emergency room.

When studying the modern history of the hospital, it is interesting to find that it has been a pioneer institution in getting national certifications such as the first hospital “Mother and Child Friendly”, “Model of Gender Equity” and provider of “Emergency Services with Improvements in Care and Respect”.

### 3.3 The Imaging Department

The patient was sobbing and seemed quite distressed during the US scanning. When the resident went out of the room without saying a word I asked her what was going on. She explained to me that she knew her baby was dead, that she knew it in her heart and she had not been able to listen to the heartbeat. I didn’t know what to say so I just grabbed her hand while we were waiting for the radiologist to come in. The radiologist came in and described the placental shape and characteristics to the resident. Due to my background, I knew that the technical terms they used meant that the placenta was normal but that the baby had died. The radiologist went out of the room. Ana started asking questions (quite unusual). She asked the resident what did they mean with” those words about the placenta”. The resident told her that they meant the placenta was normal, in the right position, that the procedure was over and she should wait outside to get the written report. He didn’t say anything about the baby. She heaved a sigh of relief, dried her tears and left the room. Horrified, I realized that the explanation of the normal placenta was interpreted as if everything was ok and that she had left the room thinking that her baby was still alive...
In Mexico, there are not US technicians as in other countries. General Practitioners enrol in a 3-4 years medical specialization course to become radiologists. Some other medical specialities include imaging courses and medical schools offer short courses. In this hospital, residents from the 4th (last) year of the gynaecology and obstetrics speciality attend the imaging department to learn how to use this technology.

Ultrasound was introduced into the hospital in 1998. According to the chief of the imaging department, it was a difficult process in which they had to prove the safety of this technology and justify its use. There are currently six machines in the unit, which are not the most up-to-date due to the lack of budget and long tender procedures.

The imaging department is located on the ground floor. After the entrance and the reception desk, there are some rooms: one for general X-rays, another for mammography, dressing-rooms, toilets (always divided: one for patients and the cleanest, with amenities, for the staff) and three little dark rooms each one with an ultrasound machine, a chair and a small couch. The US screen is part of the whole machine and it is placed next to women’s head so she is not able to see it. They do not print images since they lack the paper to do so.

The mission, vision and values that rule this department are shown in posters hanging on the walls. They express the “spirit” of this unit. The mission is: “to carry out the requested tests with high levels of technical quality, the maxim diagnostic sensibility, prompt attention and humane care”. Its vision is “to be an imaging unit that provides support with high levels of diagnostic sensibility, keeping always the humane touch when providing attention as well as turning into a top teaching and research centre for medical residents in the areas of gynaecology, obstetrics and gynaecological oncology” and its values are: honesty, human warmth, kindness, leadership, teamwork, respect and quality.

Ultrasounds are performed each morning; they are scheduled considering 20-30 minutes per patient plus extra time for cases coming from the emergency room.

The US scanning procedure in this hospital is constructed as a teaching space, a live lecture for residents in which women’s bodies become the teaching material (twice) without their previous consent:
Patients arrive with the receptionist and hand in the US request form. Then they wait until they are called. The nurses inside guide them to the rooms and help to “prepare the patient”. If it is going to be an abdominal ultrasound, the woman enters directly to the room, uncovers her belly and the nurse puts a sheet on her legs. In the cases of endovaginal US, she has to get into the dressing room, take off her clothes from the waist down and put on a gown.\(^6\)

When the patient is ready, lying down in the couch, the resident is called. The doctor introduces him/herself, explains that he will perform the US and sometimes, when it is not clear in the request form, asks the woman the reasons to make the study. During the procedure, women remain still and silent, many of them make an effort, twisting their necks, to take a look at the screen. Since they cannot see it, they look at the doctor (and also to me) like if they were trying to read from our faces.

The transducer is rubbed against women’s belly or introduced into the vagina, in which case women are asked to relax and be “flojita” (loose) which means she should relax the pelvic muscles and keep the legs wide open. For 20 to 30 minutes, the resident moves the transducer while staring at the screen, looking at the images and drawing lines with a mouse to get measurements that are then processed by the machine to calculate data such as the estimated gestational age. The doctor takes some time to write down the numbers in a napkin or a piece of paper. When there are two or more residents in the room they spend the time discussing the findings... and also chatting about any kind of topics such as the weather, the previous shift, problems with other staff members, etc. I wonder what would women think when they listen to words as “too little” “normal” “I cannot see it” but I’m not able to ask them in that moment. When the resident is on his/her own, the procedure is done in absolute silence. The woman never speaks. The resident goes out and returns with the radiologist, who performs again the scanning. Then the radiologist confirms or corrects the resident’s findings and describes the different images, explains how to use the machine and provides tips and tricks to do an ultrasound. It is common to listen to jokes about the wrong way residents do it. Sometimes, the radiologist says something to the patients; sometimes he lives it for the

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\(^6\) The use of gowns, sheets and other means to “protect patient’s modesty” is the rule in Mexico. Every time a woman will get a gynaecological revision or any other procedure that could show her genitals, she is covered as much as possible.
resident. What they basically say is that the test is over and they should wait outside for the report that is written by residents with the help of the radiologist.

When the findings were “normal” or when the US was used to determine an unknown gestational age, residents would just say that the baby was OK or that according to the study the baby was X weeks old. When the findings confirmed a pregnancy loss, they followed two patterns: not saying anything or providing brief explanations using medical and/or confusing terms such as: “the development has stopped” “no foetal heartbeat was detected” “there were not foetal movements” “your baby is not developing well”.

This obvious lack of compliance with the Imaging Department policies is grounded in the imposition of a federal program that seeks to improve the quality of care but that has not been adapted to the specific procedures of each one of the hospital’s departments and contradicts previous dynamics and expected behaviours. The National Crusade (sic) for the Quality of Health Services is a campaign instituted during the previous presidential administration. It aims to promote a “trato digno” (care with dignity or decent care) to patients. That entails, among other things, providing “complete, truthful and prompt” information that “can be understood” by the patient. This general policy has put the staff of the imaging ward in a complicated position. It has changed their role in the hospital dynamics and entails a new way of relating with patients. Before, they were expected to perform the test requested by the attending physician without disclosing any information to patients making of them inscrutable figures that were not involved with women.

Some doctors from the Imaging Department staff don’t recognize this new measure as part of their role:

When they are doing the evaluation of quality they present a concept: you have to explain the patient about her disease. That is the rule for everybody (in the hospital) but that should not be for us... It (the policy) says: ‘you will have to inform the patient about what is happening with her and her baby’... but that is for clinicians7. We try to provide a clear and concrete diagnosis, but I thought it was not our obligation, that clinicians must be the ones to tell everything.

7 “Clinicians” refers to doctors in charge of treating patients instead of working in diagnostic tasks as radiologists.
Confronted, unprepared and perhaps unsatisfied with this responsibility they were not used to, doctors distort and adapt the recommendation, providing partial information or using technical terms, attributing the attendant physician the responsibility of providing full explanations:

*We cannot just tell them ‘you know what, madam? Your baby is dead’ we save that for the clinician (meaning the doctors in the ER or the OSU\(^8\) that will see the patient afterwards), because he will have the patient seated, he will be able to explain her.... but I cannot just tell her: ‘I don’t know, they will tell you there’ we can say things such as ‘your baby is not moving’ or ‘I do not detect cardiac activity’ and then they can start imagining things.*

According to doctor’s explanations, another important factor affecting communication is work overload. Time is involved in the fact that women are not shown the screen:

*We cannot give a lot of time to the patients. How much could we say under these circumstances? Two doctors, forty patients (per 8 hours shift). Now that we are more doctors we will have more time for patients but before, if I took that time for one woman the others would be knocking down the door because the patient was urinating, because she was feeling sick, because she was bleeding or because her water had just broken... then I cannot spend a lot of time...*

*It is not the same to be in a public hospital in which you see a lot of patients in a little time, unfortunately, you have to do things very quickly, if patients can or should see the screen and they don’t do it here is because you do your utmost to get the US done and if you have time you can say merely the baby’s sex or “Madam, your baby is fine and the doctor will explain you”... it is wrong, but it is very difficult because of the amount of patients.*

But doctor’s narratives also entail notions of women’s ignorance or unwillingness to understand them:

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\(^8\) ER: Emergency Room; OSU: Obstetrical Surgical Unit
(When there is a problem with the pregnancy) *We struggle because people either blocks and do not want to understand it or really don’t understand it no matter what we say... I get tired of telling patients which conditions are present in the baby, I tell her what is wrong and at the end she stands up, cleans herself and asks: ’but my baby is fine, right?’ so... how much could I say that it is understandable? But I write down the report so the doctors can handle her, explain her... maybe in other way, “with palitos y bolitas”, the way her baby is developing*.9

According to women’s narratives, the department’s staff expectations that the doctors in the ER or the OSU will provide women with full explanations of the US findings and their health status are not precisely fulfilled.

Finally, doctors I interviewed share the view the US is an innocuous helpful diagnostic tool that “*has changed the history of gynaecology and obstetrics*”, allowing both women an doctors to diagnose pregnancies earlier and detecting “abnormalities” in foetuses. When directly asked, none of them thought it would raise any kind of ethical or moral issue. One doctor pointed out that the only thing to keep in mind in this matter was to avoid performing endovaginal US in nubile women or in those who had been victims of sexual abuse. However, I never witnessed a case in which patients were asked about those issues and I don’t think they could create the proper time and atmosphere to ask those questions, as I found later with Mara, who had been sexually abused since childhood and not only got an endovaginal US but several pelvic exams during her stay in the hospital. No one ever asked her.

3.4 The Practitioners

Mexican medical students are immersed in a complex and problematic educational system that makes it very difficult to become a gynaecology and obstetrics specialist: there are around 190 universities and schools of medicine10 that, like hospitals, are divided into public and private institutions, making accessibility dependent on economic status. The

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9 Explain something with “*palitos y bolitas*” (lit. with little sticks and little balls) means using very simple terms to explain something; it refers to the way toddlers are taught at school.

10 National Association of Medical Schools and Universities (ANUIES)
http://www.anuies.mx/la_anuies/que_es/laanuies.php
disparity between the number of applicants and the available places for students at the public universities is striking. For instance, in 2007, 3489 people applied to the biggest of the three faculties of the National Autonomous University of Mexico (UNAM), the 150th best-ranked university in the world and the first in Latin America\textsuperscript{11}. There was only place to admit 144 students.\textsuperscript{12}

Things do not improve for those who are able to enrol in medical school. After getting the General Practitioner Degree, those pursuing a medical specialty as gynaecology or radiology have to pass another filter: The National Exam for Candidates for Medical Residencies (ENARM). A process that has been in the middle of corruption accusations and scandals, and highly criticized for its rate of admission, that is around 23-29\%\textsuperscript{13}. The few students that pass the exam have then to look for a position in one of the multiple hospitals throughout the country and are chosen according to their degrees, letters of recommendation, publications, etc. This selection process plus the high social status historically accorded to doctors, makes of residents an exclusive elite group.

\textbf{3.4.1 Becoming a Specialist: a Rite of Passage.}

Davis-Floyd argues that obstetrical training in the USA is a rite of passage “\textit{through which residents are socialized into the technological model of birth, the core value and belief system of American obstetrics}” (1987: 288). Rites of passage consist of three principal stages: separation of the participants from their preceding social status, transition period in which the person has neither one status nor the other and an integration phase into the new social stage through rituals of incorporation (van Gennep in: Davis-Floyd, 1987)

The gynaecology and obstetrics residency in the Woman’s Hospital seems also to fit into Davis-Floyd’s analysis. Students are separated from their previous status when they become residents, a liminal state in which they are neither medical students nor yet gynaecologists. They spend around eight hours per day inside the hospital, plus 24 hours shifts, meaning that the resident spends 36 hours of continuous work isolated from the exterior before having one free afternoon. Depending on the hospital, and the year of the

\textsuperscript{12} From: General Direction of School Administration, UNAM: https://www.dgae.unam.mx/Junio2007/resultados/2/2080125.html
\textsuperscript{13} Official Report, Ministry of Health
residency, these night shifts can be every 2, 3 or 4 days. Physical and mental hardship breakdown is part of the construction of the process. As two of the residents explain:\textsuperscript{14}

\textit{There are some shifts that are very heavy... I woke up at 5 am, I get out of the hospital the following day at 5 pm and those are 36 hours that I was awake, you don’t sleep at all... shifts in which you are not able to have either lunch or dinner, nor breakfast... you must be there and the patient doesn’t know how many hours you have been working... the workload is huge.}

\textit{That’s the way the system is. We are the ones who do all the work; while the adscritos (doctors attached to the service, with a fixed job position in the hospital) don’t do anything, well, some of them... they come here just to sleep [...] the first year is the most difficult, you are the maid, you have to go and buy the coffees, you have to take the blood samples, you have to address your superior R’s (residents) with respect, they shout at you, they punish you ... well, officially there are not “punishment shifts” but they put them as “extra shifts to reaffirm knowledge” but it’s the same... some friends that are in other hospitals are worse than here, one friend told me that she is sexual harassed, that if she doesn’t accept to go out with the adscrito she doesn’t enter to the OR\textsuperscript{15} ...}

The cognitive transformation in which the beliefs and values of the group are adopted is a four-year process; as the resident incorporates more skills and knowledge, he gains a higher status in the hierarchy as well as more responsibility, while the night shifts and unpleasant tasks (taking blood samples, filling forms) are less. The lower status of the first-year residents and the mistreatment it entails assure the internalization of the system. As they move forward in the process, they reproduce the rules and norms they were subjected to, this compliance guarantees the continuance of the subject in the rite:

\textit{K: And what happens when you become and R2 or and R3?}

\textit{R: Well they say: I had to do it when I was an R1, now you have to do it.... I mean, it also depends on who you are, your education... your values, but the truth is that when}

\textsuperscript{14} I don’t use pseudonyms or references to sex and year of medical residency since it would make it easy for some readers to identify the participants.

\textsuperscript{15} OR: Operating Room
you become an R3 or an R4 you do the same things that they did to you, we all do this, that’s the way the residency works and if you don’t like it....

K: What then?
Well you just quit. There are many others that would like to be in your place, passing the ENARM is very difficult so if you don’t want to do it, others will.

One of the values that is internalized and that shapes doctor-patient relationships is the importance of controlling feelings and avoiding emotional attachment to patients. As the residents explained, this is a skill that comes with time, the junior residents are the sensitive ones, but time and experience allows them to learn how to “handle” their feelings:

As a resident, you have a lot of experiences, both good and bad... and in relation with the bad ones.... sometimes you have very bitter experiences, you have a very rough time, specially at the beginning, when you are starting... you have to learn how to manage the situations, learn how to manage your emotions and feelings because sometimes you get so involved with the patient that you become part of her disease... I mean, not me.... but there are doctors....

Gender plays an important role in this process; women -assumed to be more sensitive and empathic- are the ones who find it more difficult while for male residents, considered more rational, things are easier:

... female doctors are very sensitive and get interested... well, there is an interest everywhere, but they get so involved in the disease and the patient that they end up mixing their feelings with the situation that is going on... and that is very difficult. I think that it happens to some doctors, not all, but it doesn’t mean that we (the others) become insensitive.

Keeping your feelings under control doesn’t mean that things do not affect you... well if you are a man, a misogynist, a pig like many of the residents, or course it doesn’t touch you.
This control of emotions and feelings is also thought to be for the sake of patients, who supposedly require a calm and strong physician and is also a necessity in the context of work overload:

*You have to be strong, because patients expect you to be strong, they need your strength... you cannot start weeping in front of them, because they see you as someone special, someone strong that they can hold on to.*

*You cannot, as a doctor, put yourself in the patient’s shoes because you loose a limit, you cannot be crying next to the patient, it is not good for you, neither as a doctor nor as a person... I believe that, as a doctor, you cannot get involved that much with the patients, not that much that you can feel their pain, because you have a lot of patients and you wont be able to provide neither medical nor emotional support...*

Learning how to “handle your feelings” doesn’t mean that it doesn’t hurt, but it’s easier for residents to overcome a painful experience when they think a negative outcome was beyond the reach of medical power-knowledge. In addition to this a poor control of emotions could affect doctor’s performance with other patients:

*Usually, since you don’t have a lot of experience you are more sensitive. It is precisely the experience that teaches you... in my own personal case, I had had some patients that died, because they were on terminal stages, for maternal morbidity, stuff like that, but in that moment you are with the patient, it hurts you, you feel it, but as long as you know that you did everything to avoid it and that you gave the best of you, of your knowledge and skills... I remain calmed, because I know that there are many things that are not in the reach of your hands.*

*It is not that you become insensitive, you do feel it, but you handle it... you don’t let it affect your heart... but you do feel, you have to learn how to handle it, knowing how to live with it, knowing how to live with death, because it is always there, right? I did have a bad experience... I lost one of my patients... I try to think that I did anything I could... on the other hand, it may hurt me, but I rather it to hurt a lot for five minutes instead of one full day or a week... you have to control it, it cannot happen... because if you are depressed, afraid, insecure, you can make other mistakes that otherwise you*
would not make, only because you were in a bad emotional state... so you just see it as a page, you close your book and that’s all.

To sum up this chapter, the Mexican Health System is a complex fragmented structure that has been severely affected by financial crisis and political struggles, a system that so far has been incapable of fulfilling the health care needs of the population. The Woman’s Hospital is an institution in great demand, privileged in terms of both human and material resources and it is also a teaching hospital for medical residents in which women are not only patients but also “teaching materials”. Medical education is out of reach for many students, and those who manage to get one of the few places available at the residency system find themselves immersed in a socialization process that implies acceptance of a highly hierarchic structure, work overload, as well as physical and emotional hardship. It is a system that promotes the “control” of feelings and detachment from the patient as requirements to become a proficient specialist. All these factors influence the hospital’s daily practices and thus, the care women receive and that helps shape their experience of pregnancy loss.
4. Biomedicine, Biopower and Authoritative Knowledge

In this chapter, biomedical knowledge and practices related to pregnancy loss are analyzed as sociocultural constructs. First, I will introduce the ways in which pregnancy losses are labelled and reflect on the role of medical technologies in this process. Thereafter, I discuss the example of the dichotomy complete/incomplete abortion in terms of two related biomedical notions: fragmentation and the metaphor of body-as-machine. Finally, I will present the practices related to pregnancy loss in the particular context of Woman’s Hospital and discuss the ways they are informed by particular notions of risk and assumptions about women.

4.1 Labelling Pregnancy Losses

When the hospital director advised me to study all cases of pregnancy loss instead of focusing on anembryonic pregnancies I felt disappointed. However, I would later find that it would have been impossible to find patients with this condition. Looking at the medical records, nursery sheets, ID tags hanging on the wall next to women’s bed and asking doctors, I found that pregnancy loss categories and “labels” are vague, interchangeable and sometimes incomprehensible. In many cases, different labels were used to name the same patient.

One of the different ways of classifying this phenomenon was according to time; losses were divided depending on which trimester of the pregnancy it has occurred. However, these system turns out to be fuzzy when pregnancy dated can be considered according to the day of the last menstrual period or the US findings. For instance, Luisa lost her baby when she was 14 weeks pregnant according to her last menstrual period (second trimester pregnancy loss) but the ultrasound showed that the foetus size was in accordance with a 12 weeks pregnancy (first trimester pregnancy loss). Her records showed both diagnoses. The most frequent “label” I found was incomplete abortion. Others were “huevo muerto retenido” (lit. retained dead egg) and inevitable abortion.

Even though in some cases this lack of clarity in doctors diagnoses was an obvious result of negligence, omission or a simple lack of attention (for instance, basic contradictions at doctor’s notes in medical records saying it was a case of anembryonic pregnancy even after the US report described the presence of a dead foetus) the main problem in the categorization and labelling of pregnancy losses is the result of the use of medical technologies. The use of
instruments to detect and measure the levels of human chorionic gonadotropin (hCG) and ultrasound scanning have brought forward the moment of finding a pregnancy and created new categories and nomenclatures that challenge and complicate the notions of pregnancy and pregnancy loss. For instance, one of these new entities is the *biochemical pregnancy*, when the “pregnancy hormone” is found in the bloodstream but the US never shows signs of pregnancy; *blighted ovum*, in which both blood tests and US confirm a pregnancy but US scanning only shows the structures corresponding to placenta and the foetus is absent; *missed miscarriage*, when the US shows a foetus without a heartbeat before women experiment any symptom. Early detection has also made women aware of pregnancy losses that before would be considered menstrual delays and “heavy periods”.

### 4.2 Conceptualizing and Managing Pregnancy Losses

First, it is important to emphasise that I do not pretend to deny biological realities nor fully adopt some feminists’ position of reproduction as a natural process disrupted by medicalization. Medical interventions as blood transfusions and the use of antibiotics have decreased the rates of miscarriage-related mortality rates (Jalland, 1987). What is also true is that several scholars have noted that diagnostic labels and treatment approaches vary from one place to another and that the biomedical supposedly value-free knowledge is actually a mirror of the core values of a specific society (c.f. Wright & Treacher, 1982; Gaines & Hahn, 1985; Payer, 1990).

I will focus in one particular distinction among the classification of pregnancy losses that, according to biomedicine is *complete vs. incomplete abortion* and the things it tells us about the assumptions and values in which biomedicine is grounded and how, in the particular context of this hospital, this supposedly value-free knowledge is significantly shaped by these doctors views of women’s bodies and their capacities, leading to a particular way of medical management that contradicts international care guidelines.

The trend in biomedicine is to follow evidence-based guidelines and stick to the ‘value-free scientific facts’ found through research activities as randomized clinical trials and presented in international journals and books. First, I’ll provide a brief explanation of what these sources of biomedical knowledge present:
Abortion is the termination of a pregnancy before the 20 weeks of gestation or when the foetus is less than 500grs. It basically consists on the detachment and expulsion of the “products of conception” (the foetus and the related structures as the placenta). A complete abortion means that all products of conception were expelled while incomplete abortion means that some tissues are still inside women’s body.

The section on incomplete abortion in Williams Obstetrics states that in 80% of the cases, the “spontaneous resolution of pregnancy” occurs in the following days without medical intervention and that the rate of complications is the same as in cases of surgical evacuation of the uterus (curettage). The evidence-based guideline for the management of early pregnancy loss created by The Royal College of Obstetricians and Gynaecologists of the UK and adopted by several institutions and groups as the American Medical Association\textsuperscript{16} presents three options to manage early pregnancy losses:

- Expectant management, that means waiting for the woman to naturally miscarry: expectant management is an effective and acceptable method to offer women who miscarry. Expectant management for incomplete miscarriage is highly effective.
- Medical management that consists in giving medication to accelerate the natural process of miscarriage: Medical methods are an effective alternative in the management of confirmed first-trimester miscarriage.
- Surgical uterine evacuation using suction curettage that is a procedure in which instead of the curette, the sharp instrument used in curettages, a manual or electric vacuum aspiration is done: surgical uterine evacuation should be offered to women who prefer that option. Surgical uterine evacuation for miscarriage should be performed using suction curettage. Clinical indications for offering surgical evacuation include persistent excessive bleeding, haemodynamic instability, evidence of infected retained tissue, and suspected gestational trophoblastic disease. Consideration should be given to offering surgical evacuation techniques under local anaesthesia or sedation for those women who prefer that approach.

Taking into account this information, why and how is the distinction between complete and incomplete abortions constructed and why were none of the women

\textsuperscript{16} Available at: http://www.guideline.gov/summary/summary.aspx?doc_id=11379
experiencing early pregnancy losses offered either expectant or medical management but instead had a (non suction) curettage?

First, regarding the dichotomy complete/incomplete abortion, I argue that the first feature of biomedicine that is implicit in the cultural construction of these conditions is fragmentation. Several scholars have explored the way biomedicine dissects and fragments human beings (cf. Martin, 1987: Gordon in: Lock & Gordon, 1988) from broader divisions as body/mind to the recent trend of genomics and even more: proteomics (Gaines & Davis-Floyd, 2003). This separatist approach also illuminates the way body processes are conceived, like the different stages of the labour process from the beginning of contractions until the end of the delivery.

I argue that the process of pregnancy loss is also segmented. While birth is medically divided into stages (e.g. latent phase, dilation, expulsion) each one entailing diverse medical interventions; the process of abortion is fragmented or, more precisely, dichotomized. Either it is complete and all the “products of conception” had already gone out the body or it is an incomplete abortion, even though (as seen above) a high percentage of this cases would end up spontaneously without medical intervention, this separation is emphasized in the context of this hospital, where there is no time to wait for things to occur at their own pace and an immediate intervention is needed, instead of offering the “effective and acceptable” expecting management recommended by evidence-based guidelines.¹⁷

Second, closely related with fragmentation, is the Cartesian model of the body as a machine (Rothman, 1982) that still dominates medical assumptions and practices. Martin (1987) goes further and argues that not only the body-as-a-machine notion accounts for “our willingness to apply technology to birth and to intervene in the process” (1987:54) but that analogies of production in factories are applied to birth in terms of production: either the uterus is a machine that produces the baby or the woman is the labourer who produces the baby, but in both cases, the baby is the product.

In terms of this production metaphor, a pregnancy loss means that the desired product (“the healthy alive baby”) was not achieved. Instead of waiting for the miscarriage to happen

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¹⁷ None of the medical records of these women mentioned the presence of conditions considered by the guideline as indications of surgical evacuation of the uterus.
naturally, the defective product is taken out from the body through curettage. The body-as-machine is ready to move on and continue working. However, participants were told to choose a contraceptive method and wait for one year before trying to conceive again since their uterus had to recover and otherwise they would have another pregnancy loss:

*I just want to take care of myself and try again, but they told me I should wait one year before trying again, otherwise, I could abort again*- Karen

*She (the doctor) explained me that my matriz\(^{18}\) needs to heal, because they scratched it to take out everything and now it needs to recover before I can get pregnant again, if I get pregnant again, I could loose my baby again* - Vanessa

This approach is again contradicting medical literature and differs from practices in other countries; trying to conceive immediately after either a spontaneous abortion or a curettage has been proven as “safe” as delaying conception (Goldstein et al, 2002; Graziosi et al, 2005). In this hospital, the factory is temporarily closed to prevent further negative outcomes in the production.

So, why do gynaecology and obstetrics residents, eager to learn the state of the art knowledge and become proficient specialists, perform routine curettages instead of offering the evidenced-based top guidelines? First, because they need to acquire surgical skills and second, because that is what they learn in the hospital... and this apparently simple answer has a deep background:

As we have seen, rituals of incorporation to the gynaecology and obstetrics specialty include the assimilation of medical knowledge and practices through a socialization process. As Atkinson put it, medical students acquire these knowledge and skills through exemplars and firsthand experience, incorporate them into the practical reasoning to make it part of their stock of knowledge and assumptions. (in: Lock & Gordon, 1988). This medical socialization explicitly and implicitly teaches professional assumptions about biological verities (Good 1994; Good and Good 1993 in: Gaines & Davis- Floyd, 2003). Here, curettage is internalized

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\(^{18}\) “Matriz” means uterus or womb. It’s a very common expression among both doctors and lay people. It can be literally translated as matrix, mould or stub, but in Spanish it is used in terms of industrial production. For instance, a Casa Matriz (lit. Matrix House) refers to the headquarters of a given industry or the main factory.
as the best approach through the socialization process that is part of the training of residents, liminal entities acquiring the norms and beliefs of the group throughout their rite of passage.

The reasons for conceiving and practicing curettage as the best medical management are grounded in notions of risk based on paternalistic attitudes and assumptions of women as passive ignorant subjects unable to take care of themselves. It can also be understood in terms of the biopower that tells the subjects how to understand and regulate their bodies (Lupton, 1997) based on the authoritative knowledge, the one that counts as legitimate and is reinforced through hierarchical social interactions and clinical encounters (Jordan, 1993) and that is part of the learning socialization process of medical residents. We can see this in the following interview extracts:

R: We curettage everything, anembryonic pregnancies, pregnancies that seem to be complete that have a minimal endometrium... even though it looks like a complete abortion, for maximum security, you know, we cannot take the risk..

K: Risk of?

R: Retained remains, infections, basically that. If “that” remains there, it could cause from a local infection to a septic shock... and, of course, bleeding.

K: Women could bleed to death?

R: Well, it depends a lot on the gestational age, in more advanced pregnancies, yes: they could bleed severely as in postpartum haemorrhages.

K: And in earlier pregnancies as the ones I am studying?

R: Well, it's very difficult, at least at the institutional level (public hospitals) that they could let you discharge any patient with a positive pregnancy test, we cannot take the risk. When a patient is bleeding she goes to the doctor, but imagine that she is not bleeding but she has an infection, if she doesn't have the culture or the education and she is used to a bad smell down there, she won't go to the doctor until she is very complicated... and many patients live faraway and it is not easy to make them conscious, to educate them so that when they have a real emergency they can go to the hospital, so it is better to catch them, you leave them in the hospital, you leave them clean and then you send them home already using a contraceptive method.
Another resident:

**R:** We made curettages as a routine, because it is not easy to rescue all those patients, it’s better to let a patient go knowing that she doesn’t have any remains than a patient that you don’t know what will happen with her at her home, how is she going to behave, if she is going to bleed or whether she will come back with complications, so you rather curettage her, make the procedure and let her go, it is for their own safety.

**K:** I have read that in other countries they wait until women miscarriages spontaneously or use medication to speed up the process...

**R:** You can induce an abortion with misoprostol, but the days of hospitalization would be more and all that stuff... you cannot send her home because you are loosing the surveillance of your patient and something could happen, an haemorrhage, side effects of the drug, fever or something like that so you have to be monitoring her... and a natural abortion takes longer, it is possible... it is established but normally we don’t do it because risks are higher than benefits... its more risky to have a patient outside.

The risks of letting patients go without a curettage are not only for the woman, but also for the resident and the institution:

You know that maternal mortality is a big issue and authorities are alert, especially with this thing about quality\(^\text{19}\) so you cannot take the risk. Just imagine: if I let a patient go out to have her abortion at home and she dies, do you know what a big problem would that be for me and for the hospital? So it’s better to fix everything once and for all and discharge the patient with the problem fixed.

To summarize this chapter, the use of medical technologies has had an influence in reconfiguring the classification of pregnancy losses. Apart from this, biomedicine tends to fragment the human body and its processes, and to regard women’s reproductive features as analogous to industrial production. This shown in the ways pregnancy loss is segmented and in need of medical intervention to accelerate the process. This is especially evident in the context of this hospital in which doctors deploy their knowledge and exert their authority by performing unnecessary surgical procedures. The practice of routine curettages contradicts the

\(^{19}\) Refers to the Quality programme mentioned in the Imaging Department section
international care guidelines but is part of the residents’ socialization-learning process in which they internalize notions about women’s lack of capacity to take care of their bodies and the subsequent risks for both the patient and the doctor.
5. Women’s Experiences

An anthropological account of pregnancy loss necessarily deals with notions of body, self and personhood and the ways they are culturally constructed. In this chapter I explore how the technologically mediated meanings of female selves, personhood and bodies are constructed and negotiated in relation to pregnancy loss. In the first section I present how women’s bodily experiential knowledge has been undermined by the use of technologies, making of chemical tests the way to know they are pregnant and give an example of the use of US and its impact in the context of pregnancy loss. In the second, I explore the notions of self and personhood in the context of pregnancy, showing how women’s sense of self changes in the moment they find out they are pregnant and how both the “mother-to-be” and the “baby” are experienced and constructed in their social networks. In “Moving within the System” I present the ways in which women switched care providers and the reasons to do so followed by their narratives on the days they spent inside the hospital. The final section of this chapter presents an analysis of the pregnancy loss as an “assault on the sense of self” based on women’s reflections on their losses.

5.1 Technologies and Pregnancy

The use of medical technologies has changed the moment and ways in which women find out they are pregnant. The little line in the positive pregnancy test or the written words of the blood test report implicate an earlier detection of pregnancy; I found that these technologies undermined what Oakley calls “women’s bodily experiential knowledge” (In: Mitchell, 2001).

For these women, menstrual delay was a first sign that made them think about the possibility of being pregnant. Body symptoms such as nausea, breast tenderness and tiredness were associated with pregnancy only in the absence of menstruation. However, menstrual delay was just a clue or sign of the possibility of being pregnant, and it was through the use of diagnostic technologies that the pregnancy became tangible; 11 women got a pregnancy test: 8 women paid for a blood test in a private lab (3 of them at Similares) and 3 made a home pregnancy test:
My husband was taking care of me but some months ago we decided to try (to conceive)... and it worked. I was missing my period, just 4 or 5 days, but I’m very regular. I told him but we didn’t believe it, so we went to a private lab and, yes, it turned out to be that I was pregnant. – Laura

My menstruation was delayed for one week but I was not sure. I thought: well, if I am pregnant and everything is ok, great! Everything happens for a reason... I confirmed it through a blood test in a private lab, it was positive. – María

On the other hand, a negative test result was the definitive proof that the woman was not pregnant:

I had a delay, and I was also feeling some dizziness and nausea, I thought it was because my diabetes was out of control... but I wanted to be sure so I made a home pregnancy test. The result was negative so I forgot the issue and then I started to menstruate... – Mara

Two women, Luisa and Cecilia, trusted their bodily experiential knowledge. Luisa knew she was pregnant without the need of a technological confirmation:

I knew I was pregnant because my period was delayed for one month and I felt exactly the same symptoms that I had with my girl: a lot of nausea, breast tenderness, and tiredness... I didn’t get a test because I was sure. – Luisa

In Cecilia’s case, the presence of bleeding and the absence of other changes she would have expected in a pregnancy made her rule out the possibility of being pregnant. She found out she was two months pregnant few hours after the cramps and bleeding she thought were her menstruation worsened enough to seek help:

I am very irregular, I had my period the 4th and then the 20th of March, but since I am very irregular I was not worried. I had headaches and nausea but I thought it was

With “my husband takes care of me” she means that they were using withdrawal as a contraceptive method. It’s a very common (and questionable) expression.
because I started making night shifts... I was confused, but I didn’t notice any changes in my body, my breasts have not grown, they didn’t have milk... –Cecilia

Pregnancy tests were not the only interaction between women and technology. As explained in the third chapter, patients at Woman’s Hospital are not allowed to see the screen of the US. However, as I show in the next sections, most of them were receiving antenatal care in private practices in which US was part of the routine care. The previous contact with this technology had an influence on the experience of the pregnancy and its subsequent loss:

Ana got two ultrasounds at the private gynaecologist office. She learnt to interpret the visual images. For her, US was a pleasant experience, the chance to “see” her baby. It was a way of relating with the “little person” inside her body not only for her but also for her relatives, a process mediated by the doctor who performed it. Those images entailed notions not only of personhood but also of her baby’s personality, ideas that created expectations and later would form part of the senseless of losing him:

It looked like a little tadpole, you could see his head but not his limbs, you could see that someone was already living in there... you don’t need to be a doctor to understand the US, I learnt with my son, you learn the way things look. The doctor said: ‘while you are looking how beautiful he is and admire his head and hands I examine his heart, his spinal cord, his lungs... so yes, I may not be able to interpret it completely but at least I know where is the heart and when they put the colours (Doppler)... well, don’t ask me what does that mean, but come on, it looks blue and red and you can see in any anatomy book that we have blue veins and red arteries... and the boy was moving... maybe it is also that your heart helps you to understand the images. [...] When they did the second US it looked very different from the first one. Every day they change... he looked more developed, I enjoyed it a lot, he let us see his face... I went with my mother and with my husband... we saw his face and then he moved, he showed us his profile, then we started joking. The doctor said: ‘talk to him, tell him to keep still so I can measure him’ and I told him: ‘come on, my love, let us see you’ (crying) his spinal cord was perfect, a perfect line of little white dots... but he was hiding from us, that was when we thought that he was going to have a strong personality, that he wouldn’t let others take advantage of him, that’s why I don’t know why this happened...–Ana
5.2 The Construction of the Pregnant Self and the “Baby”

I use the concept of self to refer the “experience in the phenomenological sense of the term, of being a person” (Mageo, 1995:283). In the moment women confirmed they were pregnant through the use of technologies, they sense of self changed. They experienced themselves as mothers-to-be, as pregnant women, regardless whether it was it was a planned or unplanned pregnancy, welcomed or not, they were not the same person anymore.  

Erika was the only participant who reported initially feeling worried about her pregnancy:

I didn’t want to be pregnant because my son, the youngest, is only one year old...and how am I going to take care of three children? But when I saw that the test was positive I said: ‘Whatcha gonna do?’ my husband said: where two people eat, three people eat. Let’s have the third one and afterwards you can get the surgery (tubal ligation). We were worried cause we don’t have insurance, and with all the expenses, we don’t have enough money... but then I started to get excited, maybe this one would be a girl, I’ve always wanted a girl. –Erika

For the rest, a positive test result meant the embodiment of pregnancy, understanding by embodiment “the perceptual experience and mode of presence and engagement in the world” (Csordas in Mitchell, 2001: 15). Women made allusions of experiencing themselves as “creators of life”, felt joyful and started to think about the future. At the same time, women were divided, simultaneously self and the other, since the construction of the new person, the baby, also began:

They gave me the results that same day. We went together to pick them up. I was very happy, so did he (partner), I imagined all the things I was going to do with my baby... I felt it was a girl. I imagined that my belly was going to grow, actually it grew a lot, I felt some movements, I felt nauseous and cravings for fries and cake... –Gabriela

(When the test confirmed the pregnancy) We were thrilled, we had gotten what we wanted tough we never thought it would be while we were unemployed... it was very

21 More than half of these women were trying to conceive. The others were neither actively looking for a child, nor using any kind of contraceptive method.
cool. In that moment I was very happy, I felt healthy... we were not three but four people in the family... it feels great... God gives you the gift to create life and that life is the fruit of the love we feel for each other –Ana

Besides excitement, being pregnant also implied acquiring new responsibilities and norms to follow, fulfilling women’s protective role and being disciplined for the sake of the new person that is inside them as a separate individual:

I was bummed out, I couldn’t believe it (that she was pregnant) but then I started to get used to the idea that it was not just me anymore, that I had to take care of myself and being responsible of the person that was inside of me, I decided to quit my job because it may harm the baby, we started the procedures to get the military health insurance, because the father is from the army... I started taking the vitamins... –Laura

Except one woman who waited two months until disclosing her status, women immediately shared the news with relatives and friends. From this point their social position changed, both the mother-to-be and the baby were constructed inside their social networks:

I couldn’t believe it but... I mean... in a good sense, you know? I thought I was healthy.... (crying) and very thankful with God for being able to give life... it was a surprise, everybody were taking care of me, pampering me, they (the relatives she lives with) didn’t let me carry heavy things, sweeping, hand-washing... I was treated as a queen... I was feeling special. –Vanessa

I used to talk a lot with my baby, not out loud but in my mind... for example, every time I took a shower I told the baby: ‘look, son... this is water, we are taking a shower and one they you will feel it on your own skin” and I knew that some day he would remember it, that things wouldn’t be unfamiliar for him. My husband was feeling the same way, he used to talk to the baby and kissed my belly. We told our son. It was very difficult to explain it to a toddler but I told him that God had sent him a little brother and that he was growing inside my belly, that it would take some time until he was fully formed... he used to say: come on mom, bring it out (crying)... I told him that I was going to teach him how to count so he would know when was his little brother coming... –Ana
My daughter went out to buy some candies and returned next to my bed and gave me one for the baby, I was crying and he said: don’t cry mommy, I will rub your belly and she took care of me... because I had the feeling that the baby was not going to live so I used to start crying... the baby noticed it and asked what was going on and I said I had a headache and he said: “that’s not true, your belly hurts, wait a second...” and he went to grab some cream and rubbed it on my stomach saying that I would be ok after that. –Alma

Coinciding with Layne’s findings (2003) this social construction of the babies was also made by the buying, giving and arranging of things and these things “embody a number of characteristics thought to be important attributes of babies –being small in size, soft in both colour and texture...” (2003:106):

We were very happy with the arrival of the baby... (crying) I had a lot of dreams... I had already bought little Tupper-Ware... my husband’s nephew gave me baby clothes and I washed them, I put softener on them... I bought a little towel... I had all the things for my baby, my children were very excited, the boy used to ask: ‘How is my baby doing?’ And when my husband got paid last week he bought some mangos, there were some that were tiny and he said: ‘this one is for the baby’... my girl used to put her head on my belly and said: ‘hi baby, hi baby’... I mean, all of us were very excited about this baby, my husband saved some money and bought me a maternity gown... he hasn’t given me anything for mother’s day cause he didn’t have the money but he got a little job and bought it for me so I could wear it on Sunday. It remained there... because I’m not going to wear it anymore... never” –Alma

These sociocultural constructions of the pregnant self, the pregnant woman and the baby never entailed the possibility of a negative outcome. None of the women I interviewed ever thought about the chances of having a pregnancy loss. This may be explained by the fact that pregnancy losses are cultural taboos and therefore, are frequently kept in silence. Moreover, the “media hype” surrounding advances in reproductive technologies, the perceived biomedical power to guarantee a live birth and the absence of information regarding this topic in popular pregnancy books and media create false expectations among people, who see pregnancy as a process that always ends up with a live baby. (Layne, 2003)
5.3 Moving within the System

5.3.1 Before Woman’s Hospital

After finding out about their pregnancies, immersed in the medicalization of pregnancy and the role of responsible nurturing women, women thought that the next step was to search for medical care. Participant’s care seeking behaviour was shaped by (lack of) accessibility to the health system, economic factors as well as ideas attached to the quality of public and private health providers.

As I explained before, women attending this hospital lack public social security insurance and belong to not very privileged economic strata. In Mexico, there is a national program that supposedly guarantees that all women get free antenatal care in one of the multiple Health Centres, the first-level facilities from the Health Ministry. In addition to that, a new strategy was implemented in the middle of May in order to decrease maternal morbidity-mortality: the Universal and Free Health Care Programme for Mexican pregnant women. According to this policy, praised immediately by UNICEF and unknown to all my informants, any woman can get free antenatal care in any of the institutions of the health system regardless their status and type of insurance...

However, things work differently in practice. Only one of the interviewees, Alma, went to the Health Centre at the beginning of her pregnancy. Two women didn’t get antenatal care until they started bleeding or cramping: Laura and Erika.

Laura and her partner decided to enrol her daughter into a private school, since they wanted her “to get a better education”. They also asked for loans to buy furniture for their place, but Laura’s husband lost his job and they started to have a lot of debts. He later found a job as a truck driver, but since his salary is very low, they couldn’t afford the 80 pesos (4.2 Euros) that the private doctor would charge them. When I asked Laura why she hadn’t gone to the Health Centre to receive free antenatal care, she explained:

I have to take my girl to school early in the morning... and every time that I try to go to the Health Centre they tell me that they are fully booked for that day and that I should arrive earlier to get a turn, so I have to go to the private doctor. -Laura
I asked the same to Erika:

*I didn’t go to the Health Centre because the times I have gone there it takes them quite a lot, you have to arrive nearly dead so they see you. If you don’t arrive before a given hour, very early like 6 am (they open at 8) to get a turn they tell you to go the following day... so every time I get sick I go to a private doctor... and also the Health Centre is closed on Saturdays while Similares is always open, and I had taken my kids there and we trust that place –Erika*

With the exception of Cecilia, who works as a nurse and started miscarrying during her shift at this hospital, the remaining women who went to private practices (including Similares) expressed similar points of view. Either the Health Centre opening hours are not compatible with their jobs or duties as housewives, they feel unsatisfied with the waiting times or the treatment or they believe that private care is better than public. As one of the participants explained, going to a private physician meant, “doing the best” for themselves and their babies.

Women’s first choice of getting private health care changed when things “started to go wrong”. The sudden onset of symptoms like cramps and/or bleeding was the beginning of long journeys in which they switched between private and public institutions. Their swings and “choices” were determined by factors such as having or not the money to pay for private care and the capacity and availability of public services.

**Luisa**

When Luisa found out she was pregnant, she decided to go with the private gynaecologist that she usually visits. The doctor told her to wait one week since her agenda was fully booked. Luisa decided to wait and started taking prenatal vitamins. When she started feeling cramps, she called her gynaecologist again, but the doctor advised her to go to any hospital since it seemed like she was having labour pains.

Without having enough money to pay for a private hospital, she went to the same public hospital in which her daughter was born, but they didn’t admit her since the hospital was reserved for the cases of AH1NI flu. After going to four other public hospitals that rejected her for different reasons (not having gynaecologists in that moment, space in wards, blood bank services, etc.) and very worried about her baby, she went to one of the public
hospitals for insured workers. As an uninsured person, she was asked to pay the equivalent to 550 Euros that she could not afford. She went back to the second hospital she had visited, the one that didn’t have gynaecologist for the moment, and demanded care. The general practitioner examined her and told her that everything was fine. She decided to spend one week in bed rest until seeing the private gynaecologist; she still had the pain but she felt that something was moving in her belly (though the general practitioner told her it was “stupid” since she was only 12 weeks pregnant) The night before her appointment she started spotting and chose to wait to see her doctor the next morning. That day, the doctor performed an US and was not able to find the baby’s heartbeat. She sent Luisa to another place to confirm her findings. When she called her doctor to tell her about the results, she told her to come to Woman’s Hospital, that she was sure that they wouldn’t reject her here as in the other hospitals.

Alma

As in Luisa’s case, Alma also switched doctors and institutions several times, but it was not only because of the inaccessibility of the public health system but rather a search for clear information and second opinions when medical explanations had left her in the middle of the uncertainty. She first when to the Health Centre but since they do not provide ultrasound scanning service, she got it in a private lab. When she took the results back to her doctor (Dr. A) she was told that the images didn’t coincide with her dates, that the baby could not be seen yet but that everything was going to be all right. Sceptical, she went to a private physician near her place (Dr. B). He told her the same and prescribed vitamins “to make the baby grow”. One week later, she started spotting:

I was very scared because I thought that things were already wrong and I had this feeling that something was wrong since the first US.

They decided to go then to a public hospital. She was told that she had a threatened abortion that she should stay in bed as much as possible and use drugs for three days. She had to buy them since they didn’t have them available in the hospital. Three days later she was still spotting so she went with Dr. A at the health centre to ask for more drugs. The doctor explained her that as long as it was brown spotting and not red bleeding it was OK and that she should remain resting as much as possible. Once again, Alma was not satisfied with the doctor’s answer and went back to the private physician...
I knew something was not right, I had the feeling very deep inside of me and I just wanted someone to tell me the truth, to say things the way they were.

Dr. B said the same things that the doctor from the Health Centre and Alma went back to her home. Shortly after, she started bleeding heavily. Her husband took her immediately to the nearest public hospital, but they didn’t admit her because they had neither anaesthesiologists nor blood bank service. She went then to a private hospital, but she didn’t have the money to pay for it and the doctors in there recommended her to come to Woman’s Hospital...

**Laura**

For Laura, money was the main reason for not seeking antenatal care and for not getting the private health care she wanted when things started to go wrong. She started feeling abdominal pain when she was around 23 weeks pregnant. At the beginning, she thought it was normal because some of her relatives, who had given birth recently told her that they had also experienced a similar pain:

*Until one day I took the girl to school, we had to run because it was late and the pain was worse, so I went with my mother and she lent me the money to pay for the doctor. It was a government’s clinic, its very new, they charge 80 pesos (4.2 Euros).... well, first I asked for an US, they charged me 100 pesos (5.3 euros) and the doctor told me that I was 23 weeks pregnant. I asked for an US first because I thought I needed it, I thought that the baby was very low inside my belly and that it was the reason. The baby looked big, the doctor showed me the little heart, the spinal cord, the head, and that it was a boy. Then I went to see the doctor and he said I had a urinary tract infection and that it was the cause of the pain. My mother lent me the money to buy the drugs he prescribed.*

*Two days later the pain was worse. I put some hot towels on my belly and it felt better... but later I was worse. He (husband) took me to a private clinic, they told me that they needed to hospitalize me to put me an IV, but they charged 1500 pesos per day (79.7 Euros) and we didn’t have the money, so they told us to go to a public hospital, they gave me a shot for the pain and some suppositories, my mother in law gave me money for that. The next day I still had the pain, so they took me to a public*
hospital, they told me again that I had a urinary tract infection but that they were full and could not hospitalize me, the pain was worsening, I couldn’t stand it, and they took me back to the private clinic, but once again, they wanted to charge us a lot. All my family started looking for a place until someone told us to come here.

She lost her baby a couple of days after the doctors had to perform an emergency surgery since she had appendicitis.

**Gabriela**

In Gabriela’s case, as in many others, the opinions of partners and other members of the family were very important in the decision-making process. When she found out she was pregnant, she went to her mother’s gynaecologist and showed him the test results she had gotten at Similares. The doctor prescribed prenatal vitamins and folic acid and sent her to get an US. She didn’t get it because her husband said it was too early and he didn’t trust that doctor, so they went to visit another physician that her husband’s brother-in-law recommended them. After the second opinion, she waited until she was 3 months pregnant:

> Then my mother took me back with her doctor because she said it was a very good one, he ordered some blood tests and did an endovaginal US, but he couldn’t find anything again, he said: well the baby cannot be seen. He said that I needed and injection to have my period again, that I should get it and go back with him as soon as I started menstruating again... I was very sad, I wanted my baby, I didn’t want to get the injection, but my mother told me that it was the best and my husband said that it was the best because I was just playing with my feelings and we had already spent a lot of money in tests and doctors.

When she started miscarrying, her partner brought her to this hospital since his mother have said that this was a very good one and that they would receive her here.

**Antonia**

Antonia’s first reaction when she started bleeding was to look for the only place they knew, so they went to Similares. However, when she was told that she may had a threatened abortion, instead of going back to the same doctor, they asked her sister about “better” (more
expensive private) options. The sister recommended a little private hospital in which her son was born.

*We were very scared; we didn’t want to lose our baby... so we thought that it was better to go to a private practice. My sister told us about Hospital X, when her son was born. We went there and the doctor examined me. He said that they could not do anything more, that my baby, the embryo he said, had died... (crying) and that I needed a curettage, but they wanted to charge us 5000pesos (266Euros) plus the anaesthesiologist and the days of hospitalization. We didn’t have that money so we paid the consultation and went to the Hospital Y (public). They told us that they didn’t have enough beds, that we could come here (to this hospital) and that they would accept me.*

**Vanessa**

The idea that Similares is available and cheap and therefore, a good option for minor things but not reliable for more serious problem can be seen in Vanessa’s story. She went to Similares to confirm her pregnancy and get antenatal care. When she started bleeding she went directly to a private physician, because the doctor at Similares “looked very young and inexperienced” and she knew it was something serious. The private gynaecologist performed an US and told her that she was “probably miscarrying” and that she may need to have a curettage. Since the doctor didn’t work in any hospital, she advised her to come to this one.

**5.3.2 At Woman’s Hospital**

Women ended up in this hospital after long journeys and with good references about the institution. In this section I present women’s narratives on their experience from the moment they arrived to the hospital until we met in the Complicated Puerperium Ward.

The entrance point was always the Emergency Room (ER), where a resident would examine them. Sometimes, the next step was to get an US while for other women, the physical examination was enough to determine it was a pregnancy loss. In both cases, they were admitted to the Obstetric Surgical Unit (OSU), the place in which women wait while being on labour or before going to the Operating Room(OR). Some of them gave birth to their dead children in the OSU beds an then were taken to the OR to get a curettage, while others, with earlier pregnancies, didn’t have to give birth but only went through a curettage. After the
surgical procedure, they spent some time at the Recuperation room, before being taken upstairs, to the Complicated Puerperium Ward.

Half of the women arrived at the hospital at night. They were examined but the doctors told them they should wait until the next morning to get an US done, since they do not perform them during the night shift and they could not accept ultrasounds done in any other places because:

(The doctor said that) ultrasounds from outside the hospital are not reliable and that many women go to the hospital with fake ultrasounds looking for a (voluntary) abortion. -Luisa

For Luisa, as for many others, it meant spending the night knowing that she was carrying a dead baby and enduring pain and bleeding:

We (she and her partner) went back home, and it was a very long night, the longest night of my life. We spent the whole night crying and talking... we said that we hate it when people tell us that we are young, that we can have more babies... but, you know? That really bothers me, it is not that I can have more, babies are not replaceable, they are not spare parts... we said we needed to be strong because of my girl, that we should overcome this for her... we couldn’t sleep at all... I was very scared because the bleeding was getting worse and I was afraid that something bad could happen to me... and I also felt a lot of cramping, but the worst part was knowing that the baby was not alive anymore- Luisa

Women used to speak about their experiences “down there” meaning the ER-OSU-OR and recuperation ward. For most of them, it was an excruciating and painful experience. It was not only because they were loosing their babies but also because they were confronted with a hostile unknown environment, many times, without any kind of explanations about the procedures to happen or the cause of their loss.

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22 In August 2008, voluntary abortions were legalized (decriminalized) in Mexico City
Ana

Ana told me she was very angry because since she had arrived to the hospital no one have ever said that she has lost her pregnancy or that her baby was dead. While she suspected that because she was bleeding profusely and didn’t listen to the heartbeat during the ultrasound, it was not until they told her she needed a curettage that she confirmed it. She describes her experience after being admitted to the OSU:

The doctor started to examine me, it was awful because three people were asking me questions at the same time, another one was putting me this thing (the intravenous access) another one was shaving my parts and I thought “wait a minute, I don’t know what’s going on, explain me what is going to happen, what has happened to my baby” but I didn’t have the chance to speak, there were things that they were asking me but I didn’t know the answers, I felt like locked in a little box, in a cage... and they were doing many things at the same time... later I understood what was going on, but everything happened so fast and I didn’t get an explanation, I don’t know why did he die, that’s the only thing I want to know, I really need it to make sense of this pain...

I asked her if she had had a curettage. Doctors never explained her that first she had to give birth to his baby...

I swear to you that I thought that it was going to be everything, but it was awful... they started to shave me ‘open your legs, you are going to feel cold, you are going to feel hot, and how many years, and when was your first menstruation’... then a doctor arrived and he only said: ‘this is going to hurt’. He put something in my vagina and then made me took one pill. I thought that it was something that would help me to be open for the curettage... I was very very cold, shivering, my teeth were grinding, I rubbed my body and fell asleep. I woke up because I felt a very strong pain, like if someone was tearing me inside, like if they were pulling my back; I just grabbed the hand rails and felt like something was coming out from me... I asked for water, but they said I couldn’t drink anything, I told them I just wanted to wet my lips, but they said I couldn’t... I thought that was going to be all, but it was just the beginning... before going to that place, I thought that they were just going to give me anaesthesia, open me, take out the baby and that that was going to be all about...
She was feeling desperate and was willing to do anything she needed in order to stop suffering:

I was trying to make sense of things, to understand what was going on with me... but they kept putting their hands inside of me, saying: “not yet, not yet” and I thought: not yet what? What am I missing? What should I do in order to put an end to this? If they want me to walk I will walk, if they want me to do push-ups I will do them, whatever they ask... I swear to you I was willing to do anything... One of the doctors examined me, she said: “I can feel his feet, help me, mother, push” so I pushed... I delivered my baby at six o clock. Those were labour pains, I didn’t know that because my other son was born with a C-section...

Afterwards, she was taken to the OR to have a curettage. She later asked one of the doctors what has happened and the doctor explained her that she needed the surgery anyway. It seems like the doctor tried to use lay explanations...

He said I may had some remains form my baby inside and that they would rot and then I would rot too, so they had to clean me.

María

After Maria’s private gynaecologist told her to come to this hospital because she seemed to have an anembryonic pregnancy and would probably need a curettage, she came to the ER. The doctors told her that she needed to make an appointment for an US but she was not able to come because she couldn’t skip work to be here in the morning, when US are done. Few days later she started to feel pain in the “lower part of her stomach” and she recalled her previous pregnancy, when she had a threatened abortion. She came back and tried to schedule an US, but she was told that it has been a long time since she had gone to the ER and that she should go back and be seen by the doctors again. She did so...

The doctor scolded me because I hadn’t gone to my previous US appointment, I told her that I had not been able to come because of my job and she said: ‘What? Do you think your job is more important than your life?’ And I said:’ well, if there is no job, there is no food so I have to go to work’. She got angry and said: ‘you are a grown up, you should be aware about the things you are doing’ and I said: ‘yes, precisely, that’s
why I am here’. I was very angry because instead of making a patient feel better they make us feel worse.

She went back to the Imaging Ward. The written report said it was not an anembryonic pregnancy but a retained dead egg, meaning that an embryo was visible but dead...

The doctor (in the ER) said: ‘See? I told you. You were pregnant.’. well, yes, I knew I was... she said I needed a curettage, and then she said: ‘You should get the tubal ligation done, you are too old and if you get pregnant again the same thing could happen, or you could have a child with Down’s syndrome’. I accepted but not because of that, it’s just that I don’t want more children, I have two and they are strong and healthy... but yeah... they make you feel bad, they made me feel very old...

As Ana, María was overwhelmed at the OSU...

They took me to one room, it was crowded, there were like 13 beds, all of them occupied, a lot of nurses and doctors... well, we didn’t know who was who because they are wearing those funny things (scrubs) and they cover their heads and faces so you don’t know if it is a nurse, a doctor or what... it was very depressing to see all that seek people, I felt very sad to see all those women having pain, everybody was very serious... and they (staff) would go and touch them (digital vaginal examination) or to listen to the baby’s heartbeat... and I was confused, someone came and said: ‘sign here, and then here and then here’... I was not able to raise my hand, they didn’t tell my what were those papers for...

Laura

Laura also felt disappointed with the care she received. The doctor in the ER also lectured her:

I arrived to the ER at 11 am. They didn’t believe that there was something wrong since the baby was OK, I told the doctor that they didn’t want to see me in the other public hospital and she got angry. She said: ‘what do you mean when you say they didn’t want to see you?’ And I said: ‘yes, they told me I needed to be hospitalized but that
they were full’ and she said: ‘well, see? So they actually saw you, don’t come here saying that they denied you medical attention’.

The strong pain Laura felt due to the appendicitis she had, and the fact that she could not get any painkillers marked her experience:

She did a vaginal examination and then they sent me to get an US. They didn’t show me the screen, but I didn’t want to... I was in so much pain that I didn’t care, when they were rubbing the machine against my belly it hurt a lot. The doctor said the baby was fine. They took me back to the ER, I was in the wheelchair, inside, but they were not paying attention to me... the pain was so strong that I started crying... a lot. One doctor, I think she was the chief, told the others: ‘how is it possible that you ignore patients, that you see that she is crying and you don’t do anything?’ So they put me in a bed, they put an IV but they didn’t give me anything for the pain, they said they couldn’t do that because first they needed to figure out what was going on...

Then they took me to high-risk pregnancy (ward). They didn’t say anything to me, I told them that I was feeling very very bad, that I had a lot of pain, but they insisted: ‘we cannot give you anything until we have a diagnosis’. I was desperate, lying down, with the pain, without knowing anything about my family, without knowing what was going to happen with me... the worst part was the pain.

Afterwards, one of the surgeons visited her and explained her that she had appendicitis and that she needed an emergency surgery otherwise she could die. The doctor also told her that the surgery could trigger labour and that her baby was very little so survive. Her experience in the OR was shocking:

They took me to the OR and made an epidural, they started the surgery. I saw when they cut me, how they opened me, because the lamp above reflects the images. I was shaking... I couldn’t avoid it. The doctor showed me my appendix, it was long and black; then I saw when they were closing me... the anaesthesiologist said: that’s a lot fat, it was the same doctor that scolded me when she was giving me the epidural. She said: ‘why do you have so many tattoos? Don’t you care about infections? And you know you can’t donate blood any more’.
Three days later...

I started to feel another kind of pain, like if I had a lot of gasses that were trying to get out, it was a pain that started in my stomach and ran through my legs, I was writhing in pain. The doctor that made the surgery told me to walk a lot, that they couldn’t give me anything because of the baby, they didn’t want to lend me a wheelchair to go to the toilet because I needed to walk, but I was not able to do so because of the pain and I really needed to pee... and it was worse because they do not allow us to use underwear...

When the doctor examined Laura again, her baby was about to be born. She was taken to the OSU...

They took me there, they gave me another epidural... I felt distressed, scared, they left me in a bed, they did a vaginal examination several times... I was so desperate because of the pain, I just wanted it to finish, I was asking God to help me, to take my pain away regardless the status of the baby... I fell asleep and when I woke up I felt something down there, I screamed: ‘What is this? What is this?’ And my baby was born. They said: ‘the baby is born’. I asked: ‘is he alive?’ They said: ‘no’. ‘Can I see it?’ They showed him to me, he was fully formed, with dark skin, as his dad... I blessed him, told him to forgive me for all the things I have thought and that was all. Later, they told me that they have to do a “remains cleaning” because I may had pieces of placenta that remained there because I didn’t push a lot, they put me to sleep, I don’t remember clearly... when I woke up I was in the recovery room, cold, shivering.

Laura had to go back to the OR twice. The first time, because the curettage didn’t work and she still had “remains”, and another one because the wound from the appendectomy got infected.

Except for two women, the rest expressed that being in the recovery ward after the surgery had been one of the most difficult parts, because they were together with other women that had given birth and it was painful to see them with their babies:
When I opened my eyes after the surgery, I felt awful because I opened my eyes and saw many women with their babies, feeding them... it made me cry a lot, I couldn’t stop crying. I remember that one of the patients tried to comfort me, she told me she had also lost a baby but that now she had just delivered another one, that I would have another baby... I fell asleep, and every time I woke up I saw the babies and started crying again. It’s very traumatic to loose your baby, turn around and see another woman happy with her baby. –Luisa

When I woke up, I was in the room in which they have all the babies... I was very sad, worried, I don’t know why, I was cried and wanted to get out of that place, there was one woman with a baby in my right side and another in my left side, I felt awful to see them with their babies... –Gabriela

The cruellest part of all was to wake up and see all those women with their babies, listen to their crying, they were feeding them... I imagined how would that been for me if I had had my baby (crying) but I had no one- Antonia

After being in the Recuperation Ward, women were taken upstairs, to the Complicated Puerperium Ward, where I met most of them. In general terms, they were happy with the care provided by the three nurses that are in charge of the ward and used to make jokes saying that the food was so good that it didn’t seem to be hospital food.

However, they had a lot of questions. Even though pregnancy losses are frequent and their causes are many times unknown, none of these women were told that. It was striking to find out that only one of them had received an explanation of what had happened to her:

The doctor explained me that my baby had died because I didn’t take care of my diabetes and the urinary tract infection that I had... but I didn’t have any symptoms, my urine was normal, it didn’t smell bad, I didn’t have pain or itching... she said that it was because I haven’t gone to antenatal care. -Mara

They were also anxious about getting in touch with their relatives. Most of them hadn’t seen them nor heard any news about them since they were admitted to the hospital. They were allowed to have visits for 30 minutes a day and were waiting for the visiting (half) hour.
María and Alma accepted the bilateral tubal ligation doctors offered. As we saw earlier, María was convinced about her decision; she did it because she didn’t want more kids and not because the doctor told her she was too old to get pregnant again. In the case of Alma, she had some regrets...

I got it (the surgery) because they (the doctors) insisted a lot... that I had already had many pregnancies... I had the illusion to have another... well, but maybe it was the best, I don’t want to go through this again... I’m a little bit nervous because I haven’t told to my husband, I did it without asking him... but he will accept it, anyway, we said that after this baby I would get it. –Alma

Six women got the IUD before leaving the hospital, another one chose hormonal contraception. Doctors and social workers explained them that they should wait one year before trying to conceive again:

In the morning, the social worker came in and asked me if I was going to get the IUD... I said: no, I’d rather use condoms but she said that they were not as effective as the IUD I got it because they told me that I can’t get pregnant for one year because my uterus need to recover, it needs to close again... I wanted to try again immediately. –Gabriela

I used to ask women what did they think about the care they had received at the hospital. Excepting Ana, María and Laura, whose cases are presented above, they had a good impression of the services provided by the hospital staff and the available resources. However, their reference frameworks should be considered. Their positive perceptions were contrasted with previous experiences in other hospitals...

I am satisfied with the care, its fine... because here they are not rude, in other hospitals they always mistreat you: “Ms. Get up!” or very rude, they don’t think about the other’s pain, and here no, so far, they have been very nice with me... when I lost my boy, the other one, the staff was very rude “get up and take a bath, don’t cry!” they were very very rude (in other hospital). When I started crying cause I knew they
were going to do a D&C the doctor said... well, you tell us, because I don’t want you to be crying, otherwise you can sign a paper and leave... very rude... —Alma

Also, the care was very good taking into account that this is a public hospital and the amount of money they had to pay...

*They treat us well, they don’t treat us rudely... and they don’t charge a lot, I will have to pay only 1500 pesos (79.7 Euros) for everything.* —Antonia

*I think the service is ok, at least for a public hospital, they are worse at IMSS (public service for insured workers)... they treat us well, the only thing that was wrong is that they shouldn’t put us together with other women that have their babies, because it is very sad...* —Erika

Even though I didn’t ask for suggestions, participants usually said the things they would change from the hospital. The most frequent comment was related with getting full explanations:

*So far, the attention has been good, but one comment is that they should explain better... if the placenta had something wrong, if the baby had something wrong or if it was oneself... because they don’t tell us, they don’t say “this happened to you” and you don’t ask because you are in shock with the news or going out of anaesthesia, you get blocked and when you want to ask it is too late... but the care was good, we all are treated the same way and they take care of us*—Elena

### 5.4 The loss of the pregnant self and the baby

Pregnancy losses are experiences of physical and emotional suffering that are very difficult to talk about (and very difficult to present, putting into words the things that were expressed through tears, sobs, looks and gestures). When women experience a miscarriage they lose two things: their babies and their recently reconstructed selves. Regardless the time of “being pregnant” (just a few hours for Cecilia and Mara to 23 weeks for Laura) the already-under-construction mother-to-be and baby are suddenly crushed:
This is very difficult for me, I cannot assimilate it, I had illusions, dreams... hopes grew inside of me... but all of a sudden everything was lost. – Erika

A Pregnancy loss is not only an “assault on the sense of self” (Layne, 2003) but also a physical bodily experience, marked by blood and pain. According to biomedicine, bleeding is common during pregnancy and does not always mean there is a problem (Everett, 1997). However, the lay perception is that the only kind of blood that is supposed to come out from the vagina is menstrual blood, the same that is explained in physiology texts and lectures as the outcome of a failed (re)production (Martin, 1987, 1996). Some women started suddenly to spot or bleed, others started experiencing symptoms such as abdominal pain, cramps and general discomfort but didn’t get worried until they bled. Blood for these women was the scaring sign that something was seriously wrong:

When I saw the blood in the toilette paper I thought I was loosing the baby and I just shouted ‘my baby, something is wrong with my baby’ and I asked him (the baby) not to leave me, to stay with me... I thought we both were going to die, cause like 15 minutes after, I was not able to stand up, the pain was unbearable, I hadn’t had such a strong pain in all my life. - Antonia

I suddenly started to bleed and bleed, it didn’t stop. I was very scared and sad... I was in my bedroom with my husband and I wanted to go to the toilette to check me because I felt something wet. I got up from the bed and then I bled and bled and bled, a lot... I felt very bad, I actually thought I was going to die when I was watching all the blood falling down my legs... and the pain... . I didn’t have the time to cry, everything was so quick, I felt I was going to die, I felt very bad, because the bleeding was very strong, my legs were very dirty, everywhere I walked I left blood stains... I thought I was going to die together with my baby – Alma

Women embodied the abrupt absence of the already-under-construction “baby”, experiencing a void inside their bodies. At the same time, there were some things that remained: the same physical changes that were praised and expected with excitement during pregnancy were a nuisance and a painful reminder of the lost pregnancy:
My heart is better now, yesterday I wanted to cry a lot, I felt empty, an empty woman, like if I was empty inside [...] I also... I feel fat, I gained a lot of weight because of the pregnancy but now I'm not pregnant any more, just fat—María

(Crying) I feel like if I were missing some part of my body, as if they (doctors) had taken out an organ outside of me... and now look at me... my boobs are big, my nipples got darker, I still have a big belly and all the weight I have gained, but I do not have my baby with me... this is like a nightmare.—Antonia

Participants also experienced their bodies in accordance of the metaphor of the body-as-machine (Rothman, 1982; Martin, 1987); bodies as labour machines that were broken or useless and a source of concerns regarding its future re-productive capacity:

I’m afraid of not being able to have another baby, I want another baby, a little brother for my son, but I’m worried, I don’t know if my body will be useful to have another baby I feel like my body is useless... I’m afraid it may get used to expel the babies, that it will reject another baby—Vanessa

I have to face all the people who knew that I was pregnant. What am I going to tell them? That I’m useless as a mother? That my body is not able to carry a baby?—Ana

Two other elements that appeared frequently on women’s narratives were guilt and regret:

I was very sad and started crying, I did wanted my baby... I know I should have done more... I don’t know... I carried some heavy things and maybe that is what... what... harmed him.—Gabriela

I started crying, I felt sad, I felt impotence... if only I had known, If I had taken better care of myself, had rested longer, I feel guilty... I was totally dumbfounded. —Cecilia
I really don’t know why this happened. I was a healthy woman, I do not work out but I don’t eat junk food, I was not sick... —Ana
I know I should have taken care of me, of my diabetes, but I didn’t know I was pregnant... if only I had known... I know it was the sugar that killed her, because I know she was a girl—Mara
When I went to the (private) hospital and they gave me drugs I thought that maybe it was better to abort it, because we didn’t have the money... and maybe the baby felt it, he felt my rejection (crying) and that’s why he died- Erika

In some cases, part of women’s attempts to make sense of their loss involved their religious beliefs, they were angry with God:

I was very serious, I was sad, I felt like crying but I couldn’t, I was very angry at God, I told him: “I don’t know why you didn’t want to send me a baby, you knew I was going to take good care of him- Maria

I felt impotent, I was angry... against God, even though it doesn’t sound well. Why did he give it to me and then took it back? Why? I had dreams, illusions... I guess there is a reason for everything to happen –Elena

I felt like if I was in the middle of a bad dream and wanted to be woken up... I had the hope, I had the illusion that my baby would still be alive, just a little bit alive, I spent the night crying and praying I told God: “if you gave it to me, please don’t take it away from me now, there is a reason why you gave it to me”. I couldn’t sleep... a lot of things go through your mind, since the first moment you know you are pregnant you love your baby, I swear you love him and knowing that you may loose it is the worst thing that can happen. –Ana

Finally, women expressed ambivalent thoughts and feelings about going out of the hospital; their fears and worries about going back to their social networks, the ones in which they were being constructed as mothers-to-be:

I don’t even know how to return home, I wouldn’t like to arrive because of my children... I’m glad because I will see my kids, I miss them a lot and I really don’t know how they are and I am afraid because when they ask me about their little brother, what am I going to tell them?... I don’t know how to explain them what happened, the reasons why this happened, I don’t know what to tell them and I’m afraid of their reaction because they were very excited... the children were taking a lot
of care of me and I don’t know what am I going to tell them... I cannot find consolation for me, I don’t know how am I going to find consolation for them... I was thinking to ask my husband not to take my to our home but with my mother, and take the kids with me because I don’t want to arrive home. I left everything full of blood, all messy. I will have the memories, the sensations, I don’t know, I don’t want to arrive home. I’m calmed and fine here, I wouldn’t leave but for my sons, I miss them a lot, I want to go out from here for them, but for me, I don’t want to get out... –Alma

It’s very difficult to be in this situation, but here people chats with you... there (at home) my girl goes to school and my husband works all day long, everybody will keep up with their activities and I will be alone... [...] Outside, everybody will ask me and, what am I supposed to answer? –Vanessa

As soon as I go home I know I will have to assimilate that he is not here anymore, that all the plans and dreams you had... (sobs) and I don’t want to go back and see all his clothes and his cradle. –Antonia

To summarize this chapter, women’s sense of self changes in the moment they found out they are pregnant. This discovery is usually made through the use of medical technologies that prove (and in some cases dismiss) the “realness” of the pregnancy, undermining women’s bodily experiential knowledge. From that moment, the social construction of two entities is on its way: the mother-to-be and the baby. Women’s embodiment of pregnancy encompasses feelings of fullness, joy and expectations about the future. It also entails the acquisition of a new social role, including the responsibility of taking care of themselves and their babies and thus, looking for antenatal care. The construction of the baby inside women’s social networks is realized, among other things, through the acquisition of goods for the baby. The sudden onset of bodily symptoms such as bleeding or pain is a sign that the baby is in danger. For these women, it meant looking for immediate medical care. However, the constraints imposed by the Mexican health system made them move between the different components of the system and end, after long journeys, at Woman’s Hospital. The experience in this hospital was characterized by the uncertainty and fear of being in an unknown hostile place, worsened by the lack of information about the causes of their loss and the medical procedures women had to undergo and, in some cases, mistreatment. Pregnancy loss was a painful unexpected experience, in which both the baby and the mother-to-be were suddenly destroyed. Women
regarded their bodies as useless or broken, and were concerned about their future reproductive capacities. They tried to make sense of their loss, felt guilty and shame and were afraid of going back to their normal live and face their social networks.
6. Conclusions

This work presents and analyzes the narratives that a small group of women shared with me. It doesn’t pretend to be a representative account of either all low-income uninsured Mexican women experiencing a pregnancy loss or of all patients at the Woman’s Hospital. While it could be argued that some of the factors influencing these women’s experiences are structural and common (i.e. the lack of access to health care services) others were unique, related to the dynamics of the hospital and the doctors providing their services in that particular space and time as well as women’s personal ideas and notions around pregnancy and its loss.

For this group of women, having a pregnancy loss was a devastating experience. The factors that had an influence on it begin at a macro-level. The Mexican Health System was clearly ineffective in meeting these women’s care needs. For many of them, public health care was not suitable or accessible even from the moment of looking for antenatal care let alone when they were already miscarrying, as in the case of the woman who was rejected at five public hospitals because they didn’t have either space or resources to admit her. At the private level, either providers didn’t offer hospitalization services or women could not afford them. These deficiencies were an extra burden for women who besides being distressed by their physical state had to search for medical care.

Once inside Woman’s Hospital, women were immersed in an unknown environment in which the dynamics and practices diverged significantly from the official policies of quality of care. The work overload and subsequent time pressure led to inappropriate communication or lack of information. Therefore, women didn’t know what was going on with them and their babies and they didn’t know what medical procedures they would undergo. This lack of information also included the possible causes of the pregnancy loss (or at least knowing that there was not an evident cause): an omission that didn’t help ameliorate their anguish or their uncertainty.

The care these women received was influenced by assumptions and attitudes that residents learn as part of their training process. Among them, we can note the following: an assumption that women have neither the intelligence nor the ability to take care of themselves and therefore, need to be disciplined and controlled for their own good; and the necessity of
“fixing” their bodies before discharging them from the hospital. In some cases these paternalistic and underestimating attitudes also implied more evident forms of mistreatment; women were “scolded” for being fat, old or tattooed. In other cases, a lack of sensitivity or awareness of the hardship that a pregnancy loss could be, leads to hurtful practices such as placing women in the recuperation room with other patients and their newborn babies.

Women not only had to cope with the overwhelming experience inside the hospital, but also with the collapse of what they thought they were and had. A positive pregnancy test started two sociocultural constructions: the pregnant self, the way women experienced themselves as “mothers-to-be” and, the baby, the separate individual growing inside women’s wombs. The lack of awareness of the frequency of pregnancy losses -created by the silence surrounding this topic and the high expectations on the power of biomedicine in the field of reproduction- made of these experiences unexpected shocking events.

The women in this study experienced a spontaneous destruction of both their pregnant self and their baby. This event was characterized by both physical and emotional suffering. Women tried to make sense of their loss, felt guilt, regret and shame and experienced their bodies as useless, incapable of nurturing or keeping their babies; they were worried about their future reproductive capacities. Most of the participants expressed ambiguous feelings about going out of the hospital; they wanted to be reunited with their families and friends, but also they were afraid of going back to the places they had left still as mothers-to-be.

I have shown how the ineffectiveness of a highly fragmented and chronically underfunded health system, the dynamics of a hospital in which high demand puts too great a strain on resources, and the attitudes and practices instilled in junior doctors worsen the already painful experience of pregnancy loss. I believe that understanding the factors that lead to a poor medical management of pregnancy loss doesn’t make it excusable. Women should get an appropriate and compassionate health care that comprises full and prompt information, the availability of choices for medical management and support services targeted to these women’s needs. Most of these interventions do not require any economic investment but good intentions and willingness to change.
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